To: Michigan Senate Insurance Committee: June 12, 1012

Regarding: Death of our son Carson

Rebecca Marie Sharp, PR Estate of Carson Kaplan Sharp, Deceased

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PREVIOUSLY REPRESENTED BY

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As far as we knew, our first son, Carson Sharp, was a happy, healthy 16 month little boy that we loved with all our hearts before we took him to a major Hospital Emergency Room that specialized and advertised its pediatric emergency facility. Carson died that day while on a helicopter flying from this hospital to a major medical center in Ann Arbor. We couldn't be with him when he died as we were rushing from Dearborn to Ann Arbor to meet the helicopter. Carson didn't look right that morning so we took him to the Pediatric Emergency room. There, they drew blood and took tests. They never figured out what was wrong so they called for the helicopter for transfer to Ann Arbor Michigan. Now, with the help of our lawyer, we know what killed Carson. He had an easily treatable kidney outlet blockage that could have been fixed. Carson could have had a normal life. Because Carson's kidney was not working the potassium level in his blood went up to dangerous levels. Although the abnormal potassium level was

clearly displayed on the lab results at the emergency room, nobody read them. When the helicopter with doctors and nurses arrived they were given the lab results too but, again, nobody took the time to read them. In mid flight Carson's heart began to beat abnormally due to the high potassium levels in his blood. The life flight crew decided to put a tube in Carson's windpipe so they could make him more stable. To relax him for the tube they gave him a drug that contains a BLACK BOX WARNING from the FDA and the manufacturer that states it should never be used when the patient has elevated potassium. Shortly after the drug was injected, our lovely Carson's heart stopped forever. When we got to Ann Arbor, nobody would tell us what took his life and there was no mention of the drug or the potassium level in the autopsy report written weeks later by a pathologist at the same hospital. Our lawyer discovered what killed Carson when he ordered and reviewed Carson's medical records. Without a lawsuit, we would have never known what took our son's life. It took a lawyer to find out who killed our son. The doctors would not tell us.

I was so depressed that we could not have a jury decide what appropriate damages were for this careless, avoidable death of the loveliest little boy you can imagine. The Defendants made a settlement but after costs and attorneys fees were deducted and the funds divided up we were left with very little other than our grief. We needed to be able to tell our story. I thought this was America and that a right to trial by jury was a right every American had. Our founding fathers saw to it that we got this right but the Michigan legislature took it away. My lawyer tells me that now; the doctors are coming back for more tort reform, reforms that will eliminate medical malpractice cases like Carson's. It was so horrible and insulting being told by some law-maker what the value of our son's life was without even knowing him or meeting him or our family. I can tell you that like many other couples who have lost a child, we have gone on to divorce; but our grief continues. We were devastated when Carson was taken and injured

again by the system in this state. Please do not limit the rights of malpractice victims any further.

INCIDENCE OF MEDICAL ERRORS

The Congressional Budget Office (CBO) found that there were 181,000 severe injuries attributable to medical negligence in 2003.[3] The Institute for Healthcare Improvement estimates there are 15 million incidents of medical harm each year.[4] HealthGrades, the nation's leading healthcare rating organization, found that Medicare patients who experienced a patient-safety incident had a one-in-five chance of dying as a result.[5]

Researchers at the Harvard School of Medicine have found that even today, about 18 percent of patients in hospitals are injured during the course of their care and that many of those injuries are life-threatening, or even fatal.[6] The Office of the Inspector General of the U.S. Department of Health and Human Services found that one in seven Medicare patients are injured during hospital stays and that adverse events during the course of care contribute to the deaths of 180,000 patients every year.[7]

Recently the Joint Commission Center on Transforming Healthcare reported that as many as 40 wrong site, wrong side and wrong patient procedures happen every week in the U.S.[8] Similarly, researchers in Colorado recently found that surgical "never" events, such as operating on the wrong patient or wrong site or performing the wrong procedure, are occurring all too frequently[9]

Yet despite these numbers, the American public remains unaware of just how pervasive the problem is.

[1] To Err Is Human: Building a Safer Health System, Institute of Medicine, 1999

[2] Deaths/Mortality, 2005, National Center for Health Care Statistics at the Centers for Disease Control, viewed at http://www.cdc.gov/nchs/fastats/deaths.htm.

[3] Key Issues, Congressional Budget Office, December 2008, 150-154.

[4] Institute for Healthcare Improvement: Campaign – FAQs, Institute for Healthcare Improvement, http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=6.

[5] The Fifth Annual HealthGrades Patient Safety in American Hospitals Study, HealthGrades, April 2008.

[6] Christopher P. Landrigan et al., Temporal Trends in Rates of Patent Harm Resulting from Medical Care, New England Journal of Medicine, November 25, 2010.

[7] Daniel R. Levinson, Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, Department of Health and Human Services Office of the Inspector General, November 2010.

[8] Wrong Site Surgery Project, Joint Commission Center for Transforming Healthcare.

[9] Philip F. Stahel et al., Wrong-Site and Wrong-Patient Procedures in the Universal Protocol Era, Archives of Surgery, 2010;145(10):978-984.

[10] National Survey on Consumers' Experiences With Patient Safety and Quality Information, Kaiser Family Foundation, November 17, 2004.

[11] Tom Baker, The Medical Malpractice Myth, 2005.

[12] Those medical complications not covered were: Object Left in Surgery (Serious Preventable Event); Air Embolism (Serious Preventable Event); Blood Incompatibility (Serious Preventable Event); Catheter-Associated Urinary Tract Infections Pressure Ulcers (Decubitus Ulcers); Vascular Catheter-Associated Infection Surgical Site Infection Hospital Acquired Injuries, including fractures, dislocations, intracranial injury, crushing injury, and burns. See 72 F.R. 47201.